OLIVER WYMAN
HEALTH INNOVATION CENTER

A CONVERSATION WITH

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Conducted by

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In rebuilding American healthcare, one of the greatest challenges is remaking primary care. For healthcare to be effective and sustainable, primary care needs to take a much more active role in managing populations of patients, focusing on prediction and prevention to keep them well and avoid unnecessary hospitalizations and specialist visits. Perhaps the boldest example of what tomorrow's primary care could look like is provided by Iora Health, an entrepreneurial startup founded in 2011. Iora is not a matter of tweaking traditional primary care, says CEO Rushika Fernandopulle. Instead he is trying to completely redesign it with a focus on coordination, coaching, and deep relationships with patients—and achieving startling results both in quality of care and cost savings. Here, Tom Main, founder and leader of the Oliver Wyman Health Innovation Center, discusses Iora's history and vision and the road ahead for primary care with Dr. Fernandopulle, who will be a featured speaker at the center's upcoming MediFuture conference. (Interview edited for length and clarity.)

TOM MAIN Iora's a bit short of being a household name. So maybe you could start by describing what you do.

RUSHIKA FERNANDOPULLE Sure. The mission of Iora is simply to rebuild healthcare starting with primary care. A lot of what others are doing in healthcare is trying to rebuild the system top down, waiting for people in Washington to create new rules, waiting for the big health systems to somehow change things. Our first proposition is that we're going to rebuild healthcare bottom up or from the consumer in.

Our second is that we're going to start over with a clean sheet of paper. We're not going to take existing practices and make them better. We're going to build from scratch.

A third part of the fundamental change is addressing the situation where healthcare in this country and probably elsewhere has turned into a series of transactions: billing, coding, everything feels like widgets off a line. And then we try to fix healthcare by adding more transactions and more boxes to check. So our proposition is that maybe that stuff doesn't work, and the thing that causes healing is relationships; so we need to center primary care around healthy, continuous relationships.

The way I frame it is building a new operating system for primary care.

BUILDING A NEW OPERATING SYSTEM FOR PRIMARY CARE

TM That's an incredibly ambitious agenda. How do you even begin to put it into operation?

RF The first thing is changing the process. Instead of trying to see one patient at a time, we perceive our job as taking a population of people and keeping them out of trouble and improving their health. To do that, we build teams that include these folks we call health coaches, who work with patients and their data to help them make the right health decisions and manage their health. A typical practice is two doctors, eight health coaches, a nurse, a couple admin people, and a social worker to integrate mental health.

We start each day with a team huddle where we all sit around a table and talk about our patients – the discussion is guided by some great information from our insights engine. Our newer team members think we are going to spend our time mostly talking about the patients who are coming in that day – understanding the patient's needs and determining the best process flow for the patient. And we certainly do that every morning. The truth is we spend more time asking who should be coming in but isn't; who is getting into trouble and what can we do about it.

> You can get the process and the technology right; but if you have the wrong culture, those two will get subverted very quickly.

We realized that when you do this completely different process, you need a completely different IT system. Despite all the talk about electronic health records and the like, not surprisingly, the available systems are built for the current world and the current problems. So we had to invent our own.

And then the third piece, which I think is really important, is building a different culture. You can get the process and the technology right; but if you have the wrong culture, those two will get subverted very quickly.

TM Let me back you up a little bit. You talked about your ratio between team members and physicians. You also said that some of the care team really haven't been trained clinically, that actually we can engage the patient without extensive clinical training. So are you really saying that if the Iora model were a national standard, we could solve the primary care shortage crisis and improve patient health and wellness?

RF We're not trying to substitute less-than-doctors for doctors. We're saying a lot of the work primary care doctors do now—maybe 80 percent—doesn't require four years of medical school, three years of post-graduate training. We can get other people to do that, particularly when we have systems in place that can back them up. Now the key job of the doctor is to find out which of those patients fall in the 80 percent who you think could follow our protocol and then keep an eye on them because, occasionally, people will surprise you; and you realize that they're not really one of those people, and they escape. In which case, then you have to use your clinically trained mind. This is why you go through all the school, so you can figure out what's going on with this guy. He doesn't really have hypertension. He has something else that happens to manifest as hypertension, and then you need to do differential diagnoses and all those things.

There are always going to be some people with unclear diagnoses, but what we're going to see is more and more things getting codified. We're at the point now where with something simple like urinary tract infections in women, there's a lot of evidence that a doctor mostly doesn't need to be involved. A woman who's had urinary tract infections knows the symptoms, can get a strip, pee on the strip, the strip turns color. And then she can just take an antibiotic, and it fixes the UTI. There are no judgments involved in that cycle, for at least 95 percent of cases. You can imagine that set of things getting bigger and bigger.

TM But I think you just bumped into a regulatory boundary. Do you foresee a round of regulatory change that might redefine the license of a physician and increase the scope of services non-physicians can manage?

RF There are a whole host of regulatory barriers, most of which are in the guise of "protecting patients," and many of which were written 100 years ago. They make no sense whatsoever given the state of science and given the state of practice and consumers and technology. We believe our health coaches don't need medical training because the only skill they really need is the ability to connect with other human beings. Everything else we can "protocolize" and build into the system with a doctor supervising it. But in some states the health coach can't even take a blood pressure. It's ridiculous!

HAVING AN IMPACT

TM Let's move to results. Iora has been able to demonstrate impact. What's possible right now?

RF The price of entry, I think, is patient engagement, and we have patient satisfaction that's off the charts. We use a thing called Net Promoter Score to measure how people like the practice. It asks how likely you are to recommend us to a friend or colleague on a 0 to 10 scale. You take the people who love you and the people at the low end of the scale. You subtract them out and get a net number. Airlines throw parties when they break zero. Most healthcare institutions score in the 30 to 40 percent range. Cleveland Clinic scores 51 percent. The best places in the country, the Amazons and Zappos, score in the 80s. We consistently score in the 90s.

TM That's truly remarkable.

RF So patients love it. And our clinical outcomes are much, much better. Take hypertension. We know for a fact we need to control people's blood pressure. When people walk into one of our practices, only 55 percent of them with hypertension are under control. It's embarrassing! And that's the national average. Our number is above 90 percent under control.

And then there are the economics. We get independent academics to take each of the people in a practice, match them to someone who's not in the practice, and then follow the true trend lines out. It's what CMS does to evaluate their demos. Short of randomizing people, which is tricky, that's the best way to do it. We've done this repeatedly with Boeing in Seattle, with hotel workers in Atlantic City and Las Vegas, with Dartmouth College, different populations. We consistently see a 40-ish percent drop in hospitalizations compared to the control group. So, again, a 40 percent drop in hospitalizations, about half the number of ER visits, a big drop in the number of specialist visits—up to 80 percent in some places. Net healthcare spend drops about 15 percent in year one.

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>
> – Fernandopulle on the economic impact of the Iora Health primary care model

TM That you achieve a 15 percent drop out of the gates is so impressive and just shows you what's possible when you really get started. Think about the impact if models like Iora were to become the national standard.

RF We're not even using the data and the sensors and engaging the patients in the optimal way. We're maybe 20 percent of the way there. So you can only imagine where it could be if we did this right. I don't think it's realistic to think we will get rid of 100 percent of the complications of disease, but I think for sure, we can knock 30 percent off the cost. We know for a fact that 30 percent or more, maybe up to 50 of what we do is waste. Again, be clear about waste. Waste is things that not only do no benefit but actually cause harm. So it is an imperative that we get rid of this stuff. So we're now at a 15 percent net drop in spend. I feel very confident we can get to 30 percent; and you can maybe imagine we could get this to 50 percent if you really play out a lot of these other things.

DEMANDING CHANGE

TM Let's talk about the future of healthcare. When you look out over the next five years, what do you see as the big changes?

RF First, I think payers are starting to wake up, starting with the progressive, self-insured employers. If you think about what changes most industries, it's the people who sign the checks. But I think payers may be overtaken by consumers, who are the ultimate payers. Consumers may leapfrog even the progressive payers in demanding a better system.

TM Do employers stay in the game?

RF Probably the bigger ones. If you're a GE, a Boeing, maybe even a big union trust and have hundreds of thousands of lives and a staff and think about this and have a history of providing these sorts of benefits and the infrastructure to be able to negotiate, you probably will stay in the game. For smaller employers, which are really the bulk of the folks out there, it makes almost no sense to be involved.

I'm a small employer. We have literally 120 employees. Every year I have to pick a health plan for my employees, and I wonder, why am I in the health plan picking business? I ought to tell my employees, "Here's $800 a month. Go pick a health plan and healthcare that's good for you and your family and leave me out of it."

TM There have been a lot of attempts over the last decade to make the market more focused on personalized medicine, careful segmentation of members, and the ability to predict, prevent, and to expect earlier interventions. We're right at the edge of quantified self and wearable(s) and biosensors. Should we expect, in the next five years, that acute manifestations of disease will be a thing of the past?

> We don't need to give people skin in the game. They have skin in the game—their own skin. People think technology will solve things, and technology is a really important part of it. But our proposition is that the people part is part of it too.

RF Start by thinking about the way we manage disease now. We talked earlier about hypertension. We know for a fact that if we can keep your blood pressure under control, we can prevent strokes and heart attacks and kidney disease and all sorts of badness. The way we manage this, by and large, is four times a year or maybe three times a year, you come in. I take one reading and I tell you, "You should eat less salt. Take your medicines. Good luck, sucker," and you walk away. It's embarrassing to even talk about it.

This idea that a doctor will manage your health is fooling ourselves. That whole interaction we just did three times a year? That adds up to an hour. That's 8,759 hours you're not with me. So you need to understand your condition. You need to have a lot of data. What's my blood pressure in the mornings after I wake up, after I eat? You need to be able to correlate that to things you do. You need to self-titrate your medication. You need help thinking about your diet. All of that needs to happen, and that's a very different system than we have today.

TM That type of active and passive monitoring will dramatically improve prevention and give your care teams a big advantage in improving patient engagement. So you picture that kind of continuous connection and the real-time interaction with the care team as being part of the market?

RF Yes, because by and large, it's what patients want. This is your health, not my health. And you're the one who suffers the consequences. I'm dubious about the current idea that incentives will somehow solve the problem. Of course we should take away bad incentives, but we don't need to give people skin in the game. They have skin in the game—their own skin. People think technology will solve things, and technology is a really important part of it. But our proposition is that the people part is part of it too. Health can be scary stuff, and it's important to have a real human being, who can help you interpret the numbers and ask the right questions and get the right help.

TM There's a retail pharmacy on every corner. There's a pharmacist in the relationship. They're talking to the patients a couple of times a week. They could do coaching and biometric monitoring. Are they the new front end?

RF It could be a pharmacist, could be almost anyone who's trained enough to be able to provide more feedback. Meanwhile the job of the doctor goes from managing each patient to being what I call a system architect. Your job is to keep an eye on a large population of people. And then you're seeing these data streams, and you're sort of supervising these people, these coaches. It's almost like a car. On the dashboard, when you see the warning light goes on, this guy over there has either fallen off the wagon; or there's something funny about his hypertension. Maybe he doesn't have garden

variety essential hypertension; he's got some secondary cause I need to work up. Then you intervene. So it's a very different role of the physician in all of this.

TM What market trends do you see that you're factoring into the evolution of Iora?

RF There are a couple. One is that consumers are going to play a bigger and bigger role. More and more, we're building our systems and even our business models around consumer choice.

Number two is that the market's going to segment more, so the smart thing to do is build products and services for particular parts of the market. "Open a practice and treat anyone who walks through the door," is silly.

And probably the third trend is the move to self-service. The doctor and the system will do less and less and the consumer and their family will do more and more. Our job then is to give them the tools to do so. The airline industry makes you book your own tickets and check in. The banks—when did you last see a teller? In healthcare, we keep people dependent on us because our business models depend on it. And, actually, it doesn't make any sense economically.

SCALING THE NEW MODEL

TM I know you had the chance to spend some time with the CareMore leadership team, and they have strong parallels with what you're doing. They're 30 years old, and they're in 30 centers and in seven states; and you're three years old, and you're in six sites. Do you think you could be national or global over some time frame.

RF I think some nationally scaled delivery models are possible—maybe surgery centers or urgent care centers. But what we're trying to do is really take control of total healthcare. And that is much harder. This isn't like Starbucks, where you can stamp the same thing out everywhere. Healthcare is different from market to market—though it's also not chaos where it's got to be reinvented everywhere. There's a happy medium.

So we've grown. We're in six sites, soon to be 12 by the end of this year, hopefully 24 by the end of next year. You know, what's the rate that we think we can grow? I'm not sure yet. And, by the way, it's not just us. You know, on the one hand, there are a handful of folks like us—Qliance, ChenMed. What's interesting is we've all developed roughly the same model.

TM How do you lead an innovative organization like Iora?

RF Someone asked me what skills do you need to do this job? And I think it's refusal to take no for an answer. You run into all sorts of brick walls when people say no; and you simply have to ask

> What I was left with is, if you think you've got a better idea, maybe you have to just do it. And maybe what we need is just some visions of what this delivery system ought to look like, and the only way to do that is to build it.

the question a different way or find a different route. So number one is don't take no for an answer. And don't be afraid. A lot of the problem in U.S. healthcare is that people are just afraid of the future. And part of what we're trying to do is say, "People are afraid of the future because they don't know what it is." And if we can build these practices and let people come and spend time in them, they'll realize this is not scary. Not only is it not scary; this is better than what we have now? So let's actually try and do that.

TM When you were building such a disruptive model, was it difficult for the capital markets to understand you and provide the investment you needed to grow.

RF Again, we started this a long time ago when people weren't investing in healthcare services, where they were chasing the next big biotech drug. And the good news is that's changing. The other point is what we're trying to do has potentially huge return, but the timeframe is not a couple of years. This is not building the next iPhone app that Google's going to buy for whatever. This is in it for the long haul. And I think we just have to find investors who are willing to do that, who want to invest in a game-changing company, and who are willing to take it for a ride.

TM Here you are, an entrepreneur, an innovator. You've decided to build a model that's disruptive. You've worked around the system, but what people don't know is that was after a decade of happily practicing medicine in the Boston area, having great relationships with Mass General, and having your fingertips in some of the public policy changes. Why stop 10 years in? Why stop midcareer? Why reinvent?

RF So I think it really is trying to make an impact. It's not a secret when you're a practicing physician that the system we have of delivering care is broken. I think it's not because of bad intentions or bad people; it's because of bad systems.

I think a lot of doctors feel like their only alternative is to complain about it, lots of complaining. I really felt that we created this system; we have an obligation to actually try and fix it. Tried doing it from within, from within a big health system, and it became very clear that—and maybe I'm just too impatient—it just wasn't going to happen in the sort of timeframe that made sense to me. And then I had to ask myself could I see myself practicing 20 more years in this sort of hamster wheel system? And the answer was no.

You know, I spent a little time in Washington, D.C., with a consulting company. I spent some time in academia at Harvard running a health policy group, and none of those approaches seemed to really work. And, really, what I was left with is, if you think you've got a better idea, maybe you have to just do it. And maybe what we need is just some visions of what this delivery system ought to look like, and the only way to do that is to build it.

TOM MAIN

Tom Main is a Partner and U.S. Market Leader for Oliver Wyman's Health & Life Sciences practice and is the Managing Director of the Oliver Wyman Health Innovation Center. He is a trusted advisor to Boards and CEOs and a recognized thought leader on new business models, clinical models, and future market structures. Over the past decade, he has worked with nearly 100 healthcare companies on corporate strategy, development, and new business designs to transform the healthcare value equation. Prior to Oliver Wyman, Tom founded and developed ChapterHouse, a boutique healthcare consulting firm, acquired by Oliver Wyman in 2008.

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RUSHIKA FERNANDOPULLE, MD, MPP

Dr. Rushika Fernandopulle is a practicing physician and co-founder and chief executive officer of Iora Health, whose mission is to build a radically new model of primary care to improve quality and service and reduce overall expenditures. He was the first executive director of the Harvard Interfaculty Program for health systems improvement and served as a managing director of the Advisory Board Company.

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